



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

July 5, 2012

Mr. Timothy Urich, Administrator  
Rutland Healthcare and Rehabilitation Center  
46 Nichols Street  
Rutland, VT 05701-3275

Provider#: 475039

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **June 13, 2012**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS  
Licensing Chief

PC:ne

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED  
Division of  
JUL - 2 12

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		Licensing and Protection	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET</b> <b>RUTLAND, VT 05701</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An unannounced on-site complaint survey was conducted and completed at the facility by the Division of Licensing and Protection from 6/12/12 to 6/13/12. The complaint was substantiated and there were regulatory findings related to the complaint.	F 000				
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the services provided by the facility failed to meet professional standards of quality when facility staff failed to adequately monitor, reassess and follow the care plan for a leg wound for one resident (Resident #1) identified in a complaint. Findings include:  Per record review between the dates of 6/12/12 through 6/13/12 for Resident #1, the staff nurse documented on the Resident /Patient Incident Report that on 5/22/12 this resident obtained an 'injury of unknown origin' to his/her right lower leg. The resident, who was nutritionally and medically compromised with multiple co-morbidities, had extremely fragile skin with multiple skin impairments.  The nurse described the following on the incident report: "R [right] outer leg has a 8 cm length x 3 cm wide skin tear. No one knows where it came from but pt [patient] was sitting in his chair and	F 281	Plan of Correction F 281  Corrective Action: For resident #1, the wound has been monitored and the skin integrity report has been completed per policy.  Identify Other Potential Residents: In order to identify others with the potential to be affected by the same alleged deficient practice, an audit of all residents with wounds will be conducted to ensure they are assessed per policy.  Systemic Changes: Licensed staff will receive education regarding wound observation, monitoring and completion of skin integrity reports.  Monitoring: Skin Integrity Reports will be audited for completion and accuracy weekly x 4 weeks then monthly x 4 months. Results will be reviewed at Care Plan and QI committee meetings.  Responsibility: Director of Nursing Completion Date: 7/27/2012  F281 POC accepted 7/5/12 DChristensen RN/ Pmc			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

pmc

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 1</p> <p>the pad [he was sitting on] had a zipper on that side.' On this date, 5/22/12, the nurse documented on the the Skin Integrity Report Form (which the facility utilizes to describe skin impairments) the following: Pain? 'Yes.' Appearance (of the wound): Skin Tear. Description of the Wound: 8 cm length x 3 cm width. There was no undermining or tunneling, there was no drainage, the surrounding tissue was deep purple and there was no odor associated with the wound.</p> <p>Per the nursing care plan for an actual skin breakdown related to 'scab on lip and skin tear to right outer leg', the care plan documents these interventions for Resident #1:</p> <ol style="list-style-type: none"> <li>1. Evaluate the wound daily including surrounding tissue and presence or absence of drainage/infection and/or new wound pain and report to MD as indicated</li> <li>2. Provide wound treatment as ordered and</li> <li>3. Weekly wound assessment to include measurements and description of wound status.</li> </ol> <p>Per facility policy*, staff should 'perform wound observations and measurements and complete Skin Integrity Report upon initial identification of altered skin integrity, weekly, and with any deterioration of [the] wound.' Also, document the following: For wounds that do not require a daily dressing change, monitor the status of the dressing (intact and clean) status of tissue surrounding the dressing (free of new redness or swelling), and that wound pain, if present, is being completely controlled.</p> <p>Between the dates of 5/22/12 (injury) and 6/6/12 (the resident's transfer to the hospital ) the Skin</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET</b> <b>RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 2</p> <p>Integrity Report Form had only two assessments documented. The first date of wound documentation on the Skin Integrity Report was on 5/22/12 when the skin tear was discovered, and the second was on 6/6/12, the day the resident was transferred to the hospital. The Skin Integrity Report had documentation that Resident #1's wound has increased in size from 8 cm (centimeters) in length (on 5/22/12) to 22 cm in length (on 6/6/12) which is an increase of 14 cm. In addition, the wound's width went from 3 cm (5/22/12) to 9 cm (on 6/6/12) for an increase of 6 cm. in width. On 6/6/12 the surrounding tissue was described as being 'inflamed/indurated' and had an odor.</p> <p>On 6/12/12 at 2:15 P.M. per interview with the unit manager, s/he confirmed that although s/he had changed the (dermagel) dressing on 6/2/12, (for multiple areas per the TAR or Treatment Record) s/he had not completed an assessment of the right lower leg wound or completed any documentation on the Skin Integrity Report. S/he also confirmed that by not doing so, s/he was unable to evaluate whether the current treatment was promoting wound healing. The unit manager described the wound to this surveyor as follows: 'On 6/6/12 it (the wound) was necrotic, with sero-sanguineous drainage, the edges of the wound were inflamed and it was foul smelling.'</p> <p>In addition, during this same interview, another staff nurse, who, according to the TAR had changed the dressing on 5/26/12 confirmed that s/he failed to complete a wound assessment for the right lower leg wound and/or document on the Skin Integrity Report.</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 3 Refer also to F282 and F309.  *(Policy 14.6 Skin Integrity Management Genesis Centers Nursing Policies & Procedures 3.2, 3.3, 3.4, 12.1.1, 12.2 and 14.1.2 )  Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.	F 281			
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the services provided by the facility failed to be provided in accordance with the written care plan for one resident (Resident # 1) of 2 residents in the targeted sample. Findings include:  Per record review between the dates of 6/12/12 through 6/13/12 for Resident #1, the staff nurse documented on the Resident /Patient Incident Report that on 5/22/12 this resident obtained an 'injury of unknown origin' to his/her right lower leg. The resident, who was nutritionally and medically compromised with multiple co-morbidities, had extremely fragile skin with multiple skin impairments.  Per the nursing care plan for an actual skin breakdown related to 'scab on lip and skin tear to	F 282	Plan of Correction F 282  <u>Corrective Action:</u> For resident #1, treatments are completed as ordered in accordance with his plan of care.  <u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the alleged deficient practice, an audit will be completed to ensure skin integrity reports and treatment records are completed in a timely manner.  <u>Systemic Changes:</u> Licensed staff will receive education regarding wound observation, monitoring and completion of skin integrity reports.  <u>Monitoring:</u> Skin Integrity Reports and wound documentation will be audited for completion and accuracy weekly x 4 weeks then monthly x 4 months. Results will be reviewed at Care Plan and QI committee meetings. <b>Responsibility:</b> Director of Nursing <b>Completion Date:</b> 7/27/2012  <i>FABA POC accepted 7/15/12</i> <i>Dchittenden RN/ PMc</i>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET</b> <b>RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 4</p> <p>right outer leg ' the care plan documents these interventions for Resident #1:</p> <ol style="list-style-type: none"> <li>1. Evaluate the wound daily including surrounding tissue and presence or absence of drainage/infection and/or new wound pain and report to MD as indicated</li> <li>2. Provide wound treatment as ordered and</li> <li>3. Weekly wound assessment to include measurements and description of wound status.</li> </ol> <p>Between the dates of 5/22/12 (injury) and 6/6/12 (the resident's transfer to the hospital) the Skin Integrity Report Form had only two assessments documented. The first date of wound documentation on the Skin Integrity Report was on 5/22/12 when the skin tear was discovered, and the second was on 6/6/12, the day the resident was transferred to the hospital. In addition, the TAR (Treatment Record) had multiple dates when the treatment was not documented. (the dates were: 5/29/12, 5/30/12 and the dates 6/1/12 through 6/6/12) The TAR stated, 'Monitor site daily for status of dressing, surrounding tissue, s/sx of infection and wound pain.'</p> <p>On 6/12/12 at 2:15 P.M. per interview with the unit manager, s/he confirmed that the plan of care and agency policy* had 'not been followed' and that the TAR (Treatment Record) had multiple dates when the treatment 'Monitor site daily for status of dressing, surrounding tissue, s/sx of infection and wound pain' had not been documented. In addition, s/he confirmed the weekly skin assessments (to include measurements and the description of wound status) had not been done weekly.</p>	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET</b> <b>RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page 5 Refer also to F281 & F309.  *(Policy 14.6 Skin Integrity Management Genesis Centers Nursing Policies & Procedures 3.3, 3.4, 12.1.1, 12.2 and 14.2)	F 282			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide the necessary care and services for one resident (Resident # 1) to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care. Findings include:  Per record review between the dates of 6/12/12 through 6/13/12 for Resident #1, the staff nurse documented on the Resident /Patient Incident Report that on 5/22/12 this resident obtained an 'injury of unknown origin' to his/her right lower leg. The resident, who was nutritionally and medically compromised with multiple co-morbidities, had extremely fragile skin with multiple skin impairments.  The nurse described the following on the incident	F 309	Plan of Correction F 309  <u>Corrective Action:</u> For resident #1, the wound has been monitored and the skin integrity report has been completed per policy.  <u>Identify Other Potential Residents:</u> In order to identify others with the potential to be affected by the same alleged deficient practice, an audit of all residents with wounds will be conducted to ensure they are assessed per policy.  <u>Systemic Changes:</u> Licensed staff will receive education regarding wound observation, monitoring and completion of skin integrity reports.  <u>Monitoring:</u> Skin Integrity Reports will be audited for completion and accuracy weekly x 4 weeks then monthly x 4 months. Results will be reviewed at Care Plan and QI committee meetings.  <u>Responsibility:</u> Director of Nursing <u>Completion Date:</u> 7/27/2012  <i>F309 POC accepted 7/5/12</i> <i>Dchittenden RN/PMC</i>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET</b> <b>RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 6</p> <p>report: "R [right] outer leg has a 8 cm length x 3 cm wide skin tear . No one knows where it came from but pt [patient] was sitting in his chair and the pad [he was sitting on] had a zipper on that side.' On this date, 5/22/12, the nurse documented on the the Skin Integrity Report Form (which the facility utilizes to describe skin impairments) the following: Pain? 'Yes.' Appearance [of the wound]: Skin Tear. Description of the Wound: 8 cm length x 3 cm width. There was no undermining or tunneling, there was no drainage, the surrounding tissue was deep purple and there was no odor associated with the wound.</p> <p>Per facility policy, * staff should 'perform wound observations and measurements and complete Skin Integrity Report upon initial identification of altered skin integrity, weekly, and with any deterioration of [the] wound.' Also, document the following: For wounds that do not require a daily dressing change, monitor the status of the dressing (intact and clean) status of tissue surrounding the dressing (free of new redness or swelling), and that wound pain, if present, is being completely controlled.</p> <p>Between the dates of 5/22/12 (injury) and 6/6/12 (the resident's transfer to the hospital) the Skin Integrity Report Form had only two assessments documented. The first date of wound documentation on the Skin Integrity Report was on 5/22/12 when the skin tear was discovered, and the second was on 6/6/12, the day the resident was transferred to the hospital. The Skin Integrity Report had documentation that Resident #1's wound has increased in size from 8 cm (centimeters) in length (on 5/22/12) to 22 cm in</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET</b> <b>RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	<p>Continued From page 7</p> <p>length (on 6/6/12) which is an increase of 14 cm. In addition, the wound's width went from 3 cm (5/22/12) to 9 cm (on 6/6/12) for an increase of 6 cm. in width. On 6/6/12 the surrounding tissue was described as being 'inflamed/indurated' and had an odor.</p> <p>On 6/12/12 at 2:15 P.M. per interview with the unit manager, s/he confirmed that although s/he had changed the (dermagel) dressing on 6/2/12, (for multiple areas per the TAR or Treatment Record) s/he had not completed an assessment of the right lower leg wound or completed any documentation on the Skin Integrity Report. S/he also confirmed that by not doing so, s/he was unable to evaluate whether the current treatment was promoting wound healing. The unit manager described the wound to this surveyor as follows: 'On 6/6/12 it (the wound) was necrotic, with sero-sanguineous drainage, the edges of the wound were inflamed and it was foul smelling.'</p> <p>On 6/12/12 at 2:15 P.M. per interview with the unit manager, s/he also confirmed that the plan of care and agency policy* had 'not been followed' and that the TAR (Treatment Record) had multiple dates when the treatment 'Monitor site daily for status of dressing, surrounding tissue, s/sx of infection and wound pain' had not been documented. In addition, s/he confirmed the weekly skin assessments (to include measurements and the description of wound status) had not been done weekly.</p> <p>In addition, during this same interview, another staff nurse, who, according to the TAR had changed the dressing on 5/26/12 confirmed that s/he failed to complete a wound assessment for</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>RUTLAND HEALTHCARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NICHOLS STREET</b> <b>RUTLAND, VT 05701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 8 the right lower leg wound and/or document on the Skin Integrity Report.  Refer also to F281 and F282.  *(Policy 14.6 Skin Integrity Management Genesis Centers Nursing Policies & Procedures 3.2, 3.3, 3.4,	F 309			